OLR Bill Analysis

sSB 478

AN ACT CONCERNING THE DUTIES OF THE HEALTH REINSURANCE ASSOCIATION AND REQUIREMENTS OF THE CONNECTICUT SMALL EMPLOYER REINSURANCE POOL, UPDATING THE PREEXISTING CONDITIONS STATUTE, AND CONCERNING CERTAIN GROUP HEALTH INSURANCE POLICIES.

SUMMARY:

This bill requires health insurance companies to file small employer group health insurance premium rates with the insurance commissioner and prohibits them from issuing or delivering policies or certificates in Connecticut to small employers (those with up to 50 employees) unless the commissioner approves the rates (§ 29). By law, the commissioner must review and approve rates for (1) individual insurance policies and HMO plans and (2) small group HMO plans.

The bill prohibits group health insurance policies, regardless of the employer's size, from reducing a person's coverage under a policy because he or she is eligible for Medicare for any reason (e.g., age, disability, or end stage renal disease) (§ 30). It allows a coverage reduction for Medicare enrollees but only to the extent Medicare provides coverage. Current law prohibits policies issued to employers with (1) fewer than 20 employees from reducing coverage when a person is eligible for Medicare because of turning age 65 and (2) 20 or more employees from discriminating against a person in terms of benefits because he or she turned age 65.

The bill also makes numerous revisions in the insurance statutes to conform to the federal Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). The bill:

1. broadens the prohibition on insurers using preexisting condition provisions, which limit or exclude benefits because a person had a health condition before coverage was effective (§ 28);

2. prohibits insurers from using gender, industry, and group size as rating factors for small employer group health insurance policies (§§ 5 & 7);

3. allows insurers to include tobacco use, provider networks, and administrative expenses as rating factors for small employer health insurance policies (§ 8);

4. requires health insurance plans to provide a special enrollment period for eligible employees and dependents, similar to current law for late enrollees (§ 7);

5. requires insurers to make small employer health insurance policies available on a guaranteed issue basis (i.e., the insurer must accept every applicant) (§ 7);

6. eliminates a requirement that insurers offer people covered under a group policy a right to convert to individual coverage upon termination of group coverage (i.e., conversion privilege), which is no longer necessary because of guaranteed issue requirements (§§ 11 & 12); and

7. eliminates requirements that insurers, the Health Reinsurance Association (HRA), and Connecticut Small Employer Health Reinsurance Pool (CSEHRP) offer certain statutory benefit plans (§§ 1-3, 9-10, 31, & 32).

Lastly, the bill eliminates obsolete provisions and makes technical and conforming changes (§§ 4 & 13-27).

EFFECTIVE DATE: Upon passage, except for a technical change and a provision that allows insurers to include tobacco use, provider networks, and administrative expenses as rating factors for small employer health insurance policies, which are effective January 1, 2015.

§ 28 — PRE-EXISTING CONDITION PROVISIONS

The bill prohibits individual and group health insurance plans or arrangements issued by insurers, HMOs, fraternal benefit societies,

and hospital or medical service corporations from including preexisting condition provisions for covered adults. Current law already (1) prohibits preexisting condition provisions for children under age 19 and (2) generally bans the imposition of such provisions that extend beyond the first 12 months of coverage.

A "preexisting condition provision" is a policy provision limiting or excluding coverage for a condition that existed before the coverage effective date for which any medical advice, diagnosis, care, or treatment was recommended or received before the effective date.

§§ 5, 7, & 8 — SMALL EMPLOYER RATING FACTORS

The bill distinguishes between grandfathered and non-grandfathered plans with regards to permissible rating factors for small employer health insurance policies.

A "grandfathered plan" is a health insurance plan that was in existence on March 23, 2010 and has not been changed in ways that substantially reduce benefits or increase costs for consumers.

Grandfathered Plans

The bill retains current law with respect to grandfathered plans. Thus, it allows insurers to charge rates for grandfathered small employer plans that vary by age, gender, geographic area, industry, group size, and administrative cost savings for certain associations.

Non-Grandfathered Plans

For non-grandfathered plans, the bill eliminates gender, industry, group size, and administrative cost savings as rating factors.

Effective upon passage, the bill allows rates for non-grandfathered small employer plans to vary based only on (1) age, according to a uniform age rating curve the commissioner establishes, and (2) geographic area, as the commissioner defines. Effective January 1, 2015, it also allows the rates to vary based on tobacco use, but such a rate may not vary by a ratio of more than 1.5 to 1.0 and may only be applied with respect to people who can legally use tobacco. "Tobacco use" means using tobacco four or more times a week on average

within the preceding six-month period.

Effective upon the bill's passage:

1. total premium rates for family coverage under non-grandfathered plans must be determined by adding the premiums for each family member, but for children under age 21, only the premiums for the three oldest covered children will be added;

2. premium rates for a small employer group must be determined by calculating the premium rate for each covered employee and dependent and totaling the premiums attributable to each; and

3. premium rates may vary by plan based on actuarially justified differences in plan design.

Effective January 1, 2015, premium rates for non-grandfathered plans may also vary by actuarially justified amounts to reflect the plan's provider network and administrative expense differences.

§ 7 — SPECIAL ENROLLMENT PERIOD

The bill requires small employer health insurance plans to provide eligible employees and dependents a special enrollment period in accordance with federal regulation. This is similar to current state law regarding late enrollees.

Under federal regulations, a health insurance issuer may restrict enrollment to (1) an open enrollment period when people may purchase health insurance and (2) special enrollment periods when people who experience qualifying life-changing events may purchase health insurance (45 CFR 147.104). Qualifying events include changes in marriage status, dependents, or employment status, among other things. The plans must give a person 30 days from the date of a qualifying event to elect coverage.

The bill also requires plans to provide a special enrollment period for an eligible employee whom a court has ordered to provide

coverage for a spouse or minor child. The employee must request enrollment within 30 days after the court's order.

§§ 1-3, 9-10, 31, & 32 — HEALTH REINSURANCE ASSOCIATION (HRA) AND CONNECTICUT SMALL EMPLOYER HEALTH REINSURANCE POOL (CSEHRP)

HRA is a nonprofit entity whose members include insurers and HMOs doing business in Connecticut. It serves as the state's insurer of last resort. CSEHRP is a reinsurance pool through which member insurers purchase reinsurance coverage for an entire small group or for certain eligible employees or dependents in a group, generally those the insurer believes are high risk (i.e., likely to have high claim costs).

The bill eliminates the requirement that HRA make individual and group comprehensive health care plans available to people unable to obtain insurance coverage through other means. The ACA instead requires insurers to offer plans that cover essential health benefits on a guarantee issue basis. Under current law, individual and group comprehensive health care plans include specified minimum benefits, including coverage for catastrophic illness and a lifetime maximum coverage of $1 million.

The bill also eliminates the requirement that CSEHRP make special health care plans available to previously uninsured small employers. Current law requires the CSEHRP board of directors to develop these plans as a lower-cost health insurance coverage option for uninsured small employers.

The bill retains HRA and CSEHRP as the entities that will provide reinsurance in the individual and small group markets, respectively. Under the bill, HRA can administer state or federal programs that may be required or permitted, with the insurance commissioner's approval. The bill requires the CSEHRP board of directors to develop a family health statement, instead of an underwriting plan, for insurers to use to determine whether to cede lives to the reinsurance pool. The insurance commissioner must approve the statement.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 19 Nay 0 (03/20/2014)